STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	10/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN46992

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K0000	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/29/11 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/06/11 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 Surveyor: Amy Kelley, Life Safety Code Specialist At this PSR survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility was	K0000	The creation and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey reveiw on or after October 17, 2011.We respectfully request a desk reveiw in lieu of a post survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms 301 to 306 and 324 to 326. The facility has a capacity of 100 and had a census of 42 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/07/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, the National Fire Alarm Code. NFPA	K0052	K 052 The facility will ensure the fire alarm systems trouble signal is distinctive and descriptively annunciated to ensure a trouble signal can be heard in an occupied area. IEI contacted for repairs. Repairs completed	10/17/2011

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	72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants. Findings include: Based on an observation with Maintenance Supervisor on 10/06/11 at 12:10 p.m., when the automatic dialer component was placed in trouble from phone line failure a local trouble alarm was initiated. The dialer was located in the electrical/mechanical room located in the service hall which was not continually occupied therefore a trouble signal could not be heard in this location at all times. A very small visual trouble light was lit on the fire alarm annunciator panel at the third floor nurses' station. No audible alarm could be heard. Based on an interview with both staff members at the third floor desk, RN # 1 and LPN # 1, neither were aware of the trouble signal.		October 17, 2011For all residents, staff, and visitors, that could have been potentially affected, a new sounding device was ordered and installed by IEI October 17, 2011. Facility Maintenance Director/Designee in serviced all staff on October 11, 2011 to ensure they are familiar with signal and purpose and document.Facility Maintenance Director or Designee will monitor the fire alarm panel and test the trouble signal for the dialer component weekly for a month and then monthly thereafter and document.The Facility Maintenance Director or Designee will complete the Environmental and Safety CQI to ensure a trouble signal can be heard in an occupied area weekly for four weeks then monthly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by CQI team if not met. All staff in serviced and documentation completed by Facility Maintenance Director and Designee to ensure familiarity with signal and purpose. CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance.Compliance Date: October 17, 2011	

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	Based on an interview with the Maintenance Supervisor at the time of observation, the trouble light was hard to notice. This deficiency was cited on 08/29/11. The facility failed to implement a systemic plan or correction to prevent recurrence. 3.1-19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 areas used for transferring of oxygen were provided with continuous mechanical ventilation. This deficient practice could affect any resident in the third floor dining	K0143	K 143 The facility will ensure that the mechanical ventilation system will operate continuously by the Facility Maintenance Director . The O2 exhaust ventilator P-Coil on the overload switch was replaced on October 6, 2011.Potential residents on the 2 and 3 floors will not have the potential to be affected by the	10/11/2011

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	room and any staff in the second floor oxygen transferring room. Findings include: Based on an observations with the Maintenance Supervisor on 10/06/11 at 11:45 p.m., the mechanical ventilation was not operating in the oxygen transfilling/storage room on the third floor. At this time the Maintenance Supervisor went to the electrical room and flipped a switch and the mechanical ventilation motor started working. At 12:20 p.m., the mechanical ventilation was checked again and again the motor was not working. Based on an interview with the Maintenance Supervisor at the time of observation, there was an issue with the motor starter reset relay switch and it keeps interrupting power. The switch would have to be replace in order for the motor to run continuously. This deficiency was cited on 08/29/11. The facility failed to implement a systemic plan or correction to prevent recurrence.		alleged deficient practice due to the continuous mechanical device being repaired and monitored daily by the Facility Maintenance Director. The continuous mechanical ventilation system's O2 exhaust ventilator P-Coil on the overload switch was replaced by Facility Maintenance Director on October 6, 2011. Daily Environmental Safety monitoring of the function of the continuous mechanical ventilation system will be completed by Facility Maintenance Director or Designee for one week then weekly for four weeks then monthly for three months then quarterly thereafter.Environmental Safety CQI will be completed by Facility Maintenance Director/Designee daily for one week then weekly for four weeks then monthly for three months then quarterly thereafter to ensure function of the continuous mechanical ventilation system. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by CQI team if not met. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance.Compliance Date: October 6, 2011 The facility will ensure that during the oxygen transfilling process that the oxygen transfilling room door will remain closed.Potential residents on the 3 floor will not have the potential to be affected by the	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any resident in the third floor dining room. Findings include: Based on an observation with the Maintenance Supervisor on 10/06/11 at 12:11 p.m., CNA # 2 was in the third floor oxygen room transfilling from a large liquid oxygen cylinder to a small portable unit. CNA # 1 opened the oxygen room door during the transfilling process and spoke with CNA # 2. This was confirmed by the Maintenance Supervisor at the time of observation. He proceeded to explain why the oxygen transfilling room door must remain closed during the transfilling process.		alleged deficient practice by in servicing all nursing staff on October 11, 2011on policies and procedures regarding the oxygen transfilling process by the Facility Maintenance Director/Designee. All nursing staff was inserviced on policies and procedures regarding the oxygen transfilling process by the Facility Maintenance Director/Designee. The facility will monitor oxygen transfilling room and document on CQI Oxygen Therapy daily by the Facility Maintenance Director/Designee for one week then weekly for one month and then monthly for three months and then quarterly thereafter to ensure that policies and procedures regarding the transfilling process are followed.CQI Oxygen Therapy will be completed by Facility Maintenance Director or Designee daily for one week then weekly for four weeks then monthly for three months then quarterly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by CQI team if not met. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance.Compliance Date: October 11, 2011.	

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